STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155764	B. WINC			10/09/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CA	MPUS			37TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	Complaints IN IN00116313, a resulted in a p survey-Immed Complaint IN0 Substantiated to the allegation Complaint IN0 Substantiated.	and IN00117473. This artially extended liate Jeopardy. 00116232 - No deficiencies related ons are cited.	F000	00			
	are cited at F2	Elated to the allegation 225 and F226.					
	Unrelated defi	ciencies cited.					
	Survey dates: October 4, 20° Extended surv October 5 & 9	vey dates:					
	Facility number Provider number:	per: 155764					
	Survey team: Janet Adams,	RN, TC					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

010739

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155764	B. WING			10/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
000000		40110			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
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TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	Janelyn Kulik,						
	October 5, 201	2					
	Census bed type	oe:					
	SNF: 49						
	SNF/NF: 5						
	Residential: 62	2					
	Total: 116						
	Census payor	type:					
	Medicare: 43						
	Medicaid: 5						
	Other: 68						
	Total: 116						
	Sample: 3						
	Supplemental s	•					
	Residential Sa	mple: 8					
		cies also reflect state					
	findings cited in	n accordance with 410					
	IAC 16.2.						
		10/15/12 by Suzanne					
	Williams, RN						

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Event ID: FVND11

Facility ID: 010739

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/09/2012			
	ROVIDER OR SUPPLIER MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0225 SS=K	A83.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. A. Based on record review and	F0225	Resident #C was transferred to the	11/08/2012			
		F0225	Resident #C was transferred to the	11/08/2012			

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PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155764	B. WIN			10/09/2012
C OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			101 W 8	87TH AVE	
SPRING	MILL HEALTH CAN	1PUS		MERRII	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	Γ	(X5)
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	interview the fa	acility failed to ensure			hospital on 9/23/12 for evaluation	
	a thorough inve	•			and treatment of vaginal bleeding.	
	_	new onset of vaginal			We received verbal notification	
		for a resident who was			from the hospital that Resident #C	
	_				was being admitted with	
		aired and required			postmenopausal vaginal bleeding.	
		tance from staff for			The ER reported dated 9/23/12 also	
		vities of daily living.			indicated no signs of injury around	
	,	failed to ensure a			the vagina. Our plan at that time	
	_	tigation was completed			was to communicate with the family	′
	when an allega				to monitor this resident's condition	
	indicating this r	esident had injuries			with anticipated return to our facility. On October 5, 2012, ISDH	
	that were not s	elf inflicted, and a			surveyors initiated a survey at Spring	, , , , , , , , , , , , , , , , , , ,
	vaginal tear wa	s documented in			Mill Health Campus to investigate.	
	hospital record	s. This affected 1 of 3			Between the dates of 9/23/12 and	
	residents revie	wed for allegations of			10/5/12, the facility had no reason	
	abuse in the sa	imple of 3. (Resident			to investigate what was believed to	
		e lack of thorough			be a medical condition and	
	•	nis deficient practice			diagnosis. As soon as we were	
	_	al to affect the 54			notified of suspicion that the injuries	S
		ng on the health care			could have been self inflicted or	
		not protected from			otherwise inflicted, we immediately	
		I abuse, of the 116			initiated a full investigation. This	
	-				resident had already been	
	residents resid	•			transferred out of the facility when we learned of the allegation and/or	
		facility failed to			need for investigation. There was	
	immediately re				no additional need for corrective	
	_	n a timely manner for 2			action(s) for this resident.	
		n the sample of 3 who			Facility did a house wide audit of all	
		ment by staff and			incident and accidents to validate a	
	· ·	nd the employees			through investigation was	
	involved in the	allegations (Residents			completed and report to Indiana	
	#B and #D), an	d failed to initiate an			State Department of Health. No	
	investigation ar	nd report a resident to			other findings were noted. Audit	
	resident alterca	ition for 1 of 2 resident			was completed on 10/5/2012.	
	to resident alte	rcations reviewed in			All Department Heads were in	
		tal sample of 3.			serviced on 10/5/2012 by the ED,	
	- - - - - - - -	r				

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Event ID: FVND11

Facility ID: 010739

If continuation sheet Page 4 of 59

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS OUT OF WARD STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR ISC DENTIFYING INFORMATION TAG (Residents #E and #J) The Immediate Jeopardy began on 9/23/12 when Resident #C was observed with a new onset of vaginal bleeding and an investigation into the bleeding was not initiated. The facility Executive Director, Interim Director of Health Services, and Clinical Support Nurse were notified of the Immediate Jeopardy on 10/4/12 at 4:50 p.m. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on record review and interview, the facility also failed to ensure reference checks were completed during the hirring process for 1 of 5 employee files reviewed (RN #1). Findings include: A.1. The closed record for Resident #C was reviewed on 10/4/12 at 1:30 p.m. The residents diagnoses included by social services of eighteen the provided to the facility staff conducted by social services of eighteen the provider of the line was populated. The facility also failed to ensure reference checks were completed during the hirring process for 1 of 5 employee files reviewed in 10/4/12 at 1:30 p.m. The residents diagnoses included by social services of eighteen the provider of the facility will be conducted by social services of eighteen the provider of the product of the part of the provider of the	STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS (AVID SUMMARY STATEMENT OF DEFICIENCIES (INCITED PRICEINCY MIST BE PRICEIDED BY FULL REGULATORY OR LISC IDENTITYING INFORMATION) (Residents #E and #J.) The Immediate Jeopardy began on 9/23/12 when Resident #C was observed with a new onset of vaginal bleeding and an investigation into the bleeding was not initiated. The facility Executive Director, Interim Director of Health Services, and Clinical Support Nurse were notified of the Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on record review and interview, the facility also failed to ensure reference checks were completed during the hiring process for 1 of 5 employee files reviewed (RN #1). Findings include: A.1. The closed record for Resident #C was reviewed on 10/4/12 at 1:30 p.m. The resident's diagnoses SIRMET ADDRUSS, CITY, STATE, 2PCODB 101 W 87TH AVE MERRILLVILLE, IN 46410 MERRILLVILLE, IN 46410 DHS and/or SS concerning the Abuse & Neglect and Accident and incident reporting guidelines. This inservice included the expectation that all reports of alleged abuse must be immediately reported to the Executive Director of designe in his/her absence. An investigation is house begin immediately with to include reporting of required state agencies per our abuse Policy and the Elder Justice Act. Staff accused of abuse will be suspended pending investigation. In addition to department heads being trained, all staff have been inserviced on this policy 10/30/12. Resident identifiers were not provided to the facility. Facility staff conducted a survey on 10/5/2012 of interviewable residents ensure they feel safe, their needs are being met and privacy and dignity maintained. All concerns identified during this survey have been reported to the indinance of the providenc	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED
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SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410	NAME OF P	ROVIDER OR SUPPLIEF	8					
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included but were not limited to		p.m. The resid	lent's diagnoses			weekly will be conducted by Social		
Included, but were not innited to,		included, but w	ere not limited to,			Services or designee to ensure		
dementia, Alzheimer's disease, major		· ·	•			•		
depressive disorder, high blood			-					
pressure, and coronary artery Resident to resident altercations was		•	•			Resident to resident altercations wa	IS	

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Facility ID: 010739

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVI	EΥ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155764	B. WIN			10/09/2012	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1			
CDDING	MILL HEALTH CAN	ADUE			87TH AVE		
SPRING	WILL REALTH CAN	WIPUS		MEKKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COM	IPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I	DATE
	disease. The re	esident was sent to the			also reviewed with staff to make		
	hospital on 9/23/12.				sure everyone had a clear		
	·				understand that these should also		
					be considered as an allegation of		
	Review of the 8/16/12 Minimum Data Set (MDS) admission assessment				abuse in some instances. Audits to		
					continue 5 residents weekly for 90		
		esident's BIMS (Brief			days; then 3 residents weekly for 60		
		ental Status) score			days; then 2 residents weekly for 30		
	was 2. This in	dicated the resident's			days. We will review in QA monthly		
	cognitive patte	rns were severely			until substantial compliance is		
		assessment also			achieved.		
	•	esident required			Resident concerns will be reviewed		
		stance from staff for			by the Executive Director or		
					designee five (5) times per week		
	,	ne, eating, dressing,			with timely reporting of known,		
		The assessment also			suspected or alleged abuse and		
	indicated the re	esident required			immediate initiation of the		
	extensive assis	stance of two or more			investigative process. This will be a	1	
	persons for be	ed mobility and			ongoing process.		
	transfers.	•			We reviewed all personnel files to		
					ensure we were in compliance with		
	Λ care plan in	itiated on 8/13/12,			all aspects of our Abuse and Neglect	:	
		· · · · · · · · · · · · · · · · · · ·			Procedural Guidelines. Part of our		
		esident had impaired			guidelines include obtaining		
	. •	as evidenced by			reference checks for all employees.		
		ig problems and			Any personnel files identified that		
	memory proble	ems. Another care			were missing reference checks have		
	plan, initiated of	on 8/13/12, indicated			been corrected. Department Heads		
	the resident ha				have been re-trained on the		
		n, or the potential for,			importance of obtaining these		
		language was not			reference checks. Our HR Manager		
					will oversee compliance with this		
	•	plan interventions			expectation. All new employees		
		communication board			hired will have reference checks		
	to be utilized a	s an alternate form of			completed before they complete		
	communicating] .			orientation. This will be reported to		
					QA Committee monthly x 4 months		
	The 9/2012 Nu	ırses' Notes were			then randomly thereafter until		
		first entry made on			concern is determined resolved by		
	I ICVICATOR IIIC	mot criti y made on					

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PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG 9/23/12 was completed at 10:00 a.m. This entry indicated the resident presented with vaginal bleeding. The Physician and family were notified and orders were obtained to send the resident to the hospital for an evaluation and treatment. There was no assessment of the resident's vaginal area in this entry. There was only one entry made on 9/22/12. This entry was made at 11:00 a.m. There was no documentation of the resident having any vaginal bleeding in this entry. There was only one entry made on 9/21/12. This entry was made at 5:00 p.m. There was no documentation of the resident having SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG OA committee. QA will monitor for any trends and make recommendation to plan of correction as needed. QA will monitor for six (6) months or until compliance is achieved. Correction of citation is 11/8/12 Correction of citation is 11/8/12	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE (COMPL 10/09/	ETED		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 9/23/12 was completed at 10:00 a.m. This entry indicated the resident presented with vaginal bleeding. The Physician and family were notified and orders were obtained to send the resident to the hospital for an evaluation and treatment. There was no assessment of the resident's vaginal area in this entry. There was only one entry made on 9/22/12. This entry was made at 11:00 a.m. There was no documentation of the resident having any vaginal bleeding in this entry. There was only one entry made on 9/21/12. This entry was made at 5:00 p.m. There was no documentation of the resident having				101 W 87TH AVE					
This entry indicated the resident presented with vaginal bleeding. The Physician and family were notified and orders were obtained to send the resident to the hospital for an evaluation and treatment. There was no assessment of the resident's vaginal area in this entry. There was only one entry made on 9/22/12. This entry was made at 11:00 a.m. There was no documentation of the resident having any vaginal bleeding in this entry. There was only one entry made on 9/21/12. This entry was made at 5:00 p.m. There was no documentation of the resident having	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
any vaginal bleeding in this entry. Hospital documents from the Emergency Room, which were in the resident's clinical record, were reviewed. There was a faxed date of 9/28/12 typed on the top right hand corner, indicating they were faxed to the facility on 9/28/12. Emergency Room records dated 9/23/12 indicated the resident was sent to the Emergency Room for an evaluation of vaginal bleeding, and the resident had a history of having a hysterectomy and cardiac surgery. The records indicated there was bleeding around the vagina, no signs of injury around the vagina, and blood	1AG	9/23/12 was contributed by the records in bleeding around a presented with Physician and and orders were resident to the evaluation and no assessment vaginal area in only one entry entry was mad was no documbaving any vaginal area in only one entry entry was mad was no documbaving any vaginal bleeding area on 9/21/made at 5:00 procumentation any vaginal bleeding around the facility on 9/28/12 typed of the facility on 9/28/12	cated the resident vaginal bleeding. The family were notified re obtained to send the hospital for an treatment. There was t of the resident's this entry. There was made on 9/22/12. This e at 11:00 a.m. There entation of the resident ginal bleeding in this vas only one entry 12. This entry was o.m. There was no of the resident having reding in this entry. There was no of the resident having reding in this entry. There was no of the resident having reding in the early were re was a faxed date of on the top right hand ong they were faxed to 0/28/12. Emergency dated 9/23/12 resident was sent to the redom for an evaluation of ong, and the resident of having a red cardiac surgery. dicated there was of the vagina, no signs		IAG	QA committee. QA will monitor for any trends and make recommendation to plan of correction as needed. QA will monitor for six (6) months or until compliance is achieved.		DATE	

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Event ID: FVND11

Facility ID: 010739

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/09	ETED	
	PROVIDER OR SUPPLIER		101 W 8	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN 46410	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The records also Physician was cervix due to the uncooperative, follow command orientated. Additional hospobtained on 10 9/23/12 International completed by the resident's at the facility sheem indicated the recommunicate at Alzheimer's diswas seen in the The note confirmation having bleeding mote the rectumble indicated the recommunicated the recommunicated the recommunicated the recommunicated the recommunicated the recommunicated indicated the recommunicated indicated the recommunicated indicated indica	arge from the vagina. So indicated the unable to evaluate the peresident being as the resident did not did and was not so ital records were 1/4/12 at 3:00 p.m. A light Medicine note, the Physician who was attending Physician at was admitted from, esident was not able to anything, had severe the ease, and the resident was grown the vagina and a pelvic examination esident was actively the vagina and no oted upon a rectal the ease indicated the eatus post and the cause of the ot very clear and a insultation was to be other evaluation. The eated the resident vaginal wall cancer of esibility of maceration eet should also be demented patient which				

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Event ID: FVND11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155764	A. BUI	LDING	00	COMPLETED 10/09/2012
		155764	B. WIN			10/09/2012
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE	
SPRING	MILL HEALTH CAN	MPUS			37TH AVE _LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	may have caus	sed laceration and				
	bleeding."					
	A Gynecology	Consult Note dated				
	9/23/12 indicat	ed the resident was				
		ginal bleeding and an				
		nder anesthesia was				
		25/12 Physician				
	. •	, completed by the				
		nding Physician,				
		Synecologist "observed				
		a tear and other than				
		s a yellow fluid came				
		concerned that she may er vagina wall with a				
		d may have even				
		inary bladder wall."				
	Tupture [Sic] un	iliary biadder wall.				
	An Operative F	Record dated 9/26/12				
	indicated an ex	camination was				
	performed und	er anesthesia and a				
	speculum exar	nination was done.				
		s were noted at the				
	•	nd some bleeding was				
	noted. The ab	rasions were				
	cauterized.					
	A 0/26/12 Db.	cician Progress Note				
		sician Progress Note, he resident's attending				
		cated the resident had				
	1	nation under general				
		d was found to have a				
		na. The Assessment				
	_	note indicated "vaginal				
		she masturbate with a				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE S COMPL	
ANDILAN	or connection	155764		LDING	00	10/09/	
		100704	B. WIN		DDDDGG GYMY GM ME GYD GODD	10/03/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	//PUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	· ·	was it a sexual abuse					
		nome cannot be					
		patient is demented					
	and cannot giv	e a nistory"					
	When interview	ved on 10/4/12 at 2:10					
		orker #1 indicated the					
	•	came into the facility to					
	pick up the res	ident's dentures and					
	eye glasses on	9/24/12. The Social					
	Worker indicate	ed she gave them to					
	the resident's s	on at that time. The					
	Social Worker	indicated the resident's					
	son did not say	anything about the					
	resident's cond	lition at this time. The					
	Social worker i	ndicated the resident's					
	son came back	to the facility another					
	time after the a	bove date. The Social					
	Worker indicate	ed he came back to the					
	facility with and	other person. The					
	Social Worker	indicated she could not					
		exact date of this visit.					
	The Social Wo	rker indicated she					
		how he was doing and					
		r told the son "don't					
	, , ,	The Social Worker					
		hen asked the son and					
	the other visito						
		ng and requested they					
		office to talk. The					
		indicated the other					
		d "she has injuries and					
	-	If inflicted, and we may					
		The Social Worker					
	indicated to bo	th of them she was					

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Event ID: FVND11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THIND I LIMIT	or conduction	155764		LDING		10/09/	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	10,00	
NAME OF F	PROVIDER OR SUPPLIER				B7TH AVE		
SPRING	MILL HEALTH CAN	//PUS			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	0	e Executive Director to					
		with them. The Social					
		ed she tried calling and					
		cutive Director while					
		still in her office but					
	_	answer, and the and the other visitor					
		iness card and left the					
	•	cial Worker indicated					
	,	to the Executive					
		e and informed her					
		ened in her office, and					
		indicated the resident					
		at were not self inflicted					
	_	ard to the Executive					
	Director.	ara to the Executive					
	D 00.01.						
	When interview	ved on 10/4/12 at 2:35					
	p.m., the Exec	utive Director indicated					
		ker informed her of the					
	resident's son	and the visitor being in					
	the facility and	indicating the resident					
	had some vagi	nal bleeding and it was					
	"not self inflicte	d." She indicated this					
	was either last	Thursday or Friday.					
	The Executive	Director indicated at					
	that time she r	eviewed the resident's					
		and called the hospital					
	_	ncy Room records.					
	The Executive	Director reviewed the					
	•	cords that were in the					
		rd and indicated the					
		written on the records					
		ne visitors were in and					
	this date was 9	/28/12. The Executive					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ĺ		INSTRUCTION 00	(X3) DATE COMPL	
		155764	A. BUIL B. WING			10/09/	
	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE B7TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Director indicates spoke with the for the resident sent to the hose CNA who was the Nurse who before. The National bleeding the first time the vaginal bleeding in the first time the vaginal bleeding in the shift. When interview p.m., the Executive Directly and bleeding in the there had been resident, and executive Directly staff members no written state. The facility pool Neglect Procedure weed on 1 The policy had 9/16/2011. The Executive Directly and 1 Executive Directly and 1 Executive Directly and 1 The policy had 1 Executive Directly and 1 The policy had 1 Executive Directly and 1 The policy had 1 Executive Directly and 1 The Executive Directly and 1 The policy had 1 The	ited she also then Nurse who was caring it at the time she was spital on 9/23/12, the working that shift, and worked the shift lurse who sent the of the hospital for the ing indicated this was ne resident had any ing. The Nurse on the cated there were no the resident in the night wed on 10/4/12 at 3:20 cutive Director indicated the male CNA caring for in the day she was sent ergency Room and the had noticed any the resident's brief or if in any problems with the mone were voiced. The exter indicated the three the were interviewed, but the ments were available. Iticy, titled "Abuse and dural Guidelines," was 0/4/12 at 12:45 p.m. If a revised date of the policy indicated the the cotor was accountable the gand reporting					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CON		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155764	B. WING			10/09/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
					7TH AVE		
SPRING	MILL HEALTH CA	MPUS	MEF	RRILI	LVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	_	DEFICIENCY)		DATE
	_	he policy also indicated					
		nd Accident Program					
		rred to for investigation					
	procedures.						
		licy, titled "Accident and					
	I	rting Guidelines," was					
		0/4/12 at 2:00 p.m. The					
		ed 11/2010. The policy					
		ccidents, incidents, and					
	_	abuse, including injuries					
		ource, were to be					
	-	e department supervisor					
		covered or when					
		occurrence is learned.					
		o indicated reporting of					
	·	dents, and abuse to					
		ral agencies shall be in					
	accordance w	th agency guidelines.					
	The loops a diet.	a laanandu that hanan					
		e Jeopardy that began					
		s removed on 10/5/12 ty inserviced staff on					
		•					
		icy and procedures and					
		unusual occurrence to					
	•	or at the time of the					
		Il staff working on een inserviced. The					
		Director of Nursing					
	1 -	ing of all facility					
		h a monitoring system					
		n employee was					
		or to the start of their					
		d shift. Department					
	Heads were in	serviced on the facility					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE (COMPL		
ANDILAN	or connection	155764		LDING	00	10/09/	
		100701	B. WIN		A DDDDEGG CITY OT ATE TIP CORE	10/03/	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ncident Reporting					
	•	clude immediate					
	reporting to the						
	,	Director of Health					
	Services) and i						
	_	Random verbal audits					
		lents were initiated to					
		ts felt safe and their					
		dressed. The audits					
		ie. An investigation of					
	_	ssigned as working the					
		rs prior to the incident					
		ncident logs from					
		ent were reviewed for					
		ntial occurrences.					
	The Immediate						
		/5/12 at 6:00 p.m., but					
	•	remained at the lower					
	•	erity of pattern, no					
	than minimal h	th potential for more					
	Immediate Jeo	•					
	_	ded to be provided to					
	•	returning to work and ded to ensure ongoing					
	_	• •					
	_	in place to ensure all buse or mistreatment					
	were evaluated						
	weie evaluated	i inorouginy.					
	Δ2 The recor	d for Resident #B was					
		0/4/12 at 10:00 a.m.					
		diagnoses included,					
	but were not lir	•					
		·					
	steriosis, breas	t cancer, and coronary					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155764	B. WIN			10/09/	2012
NAME OF B	DOLUDED OD GLIDDLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	•	The 7/5/2012					
		Set (MDS) admission					
		dicated the BIMS (Brief					
		lental Status) score					
		score indicated the					
	resident's cogr	nitive patterns were					
	intact.						
	An Indiana Sta	te Department of					
	Health Incident	t Report Form was					
	reviewed on 10	0/4/12 at 10:30 a.m.					
	This incident re	eport form indicated an					
	incident occurr	red on 8/12/12 at 3:45					
	p.m. The form	indicated the resident					
	reported she d	id not want the CNA					
	•	ght shift taking care of					
	· · · · · · · · · · · · · · · · · · ·	A was mean and nasty.					
		cated the Immediate					
	•	cluded suspension of					
		itiating an investigation.					
		indicated the Executive					
	Director was no						
	Director was in	ounou.					
	An Accident/In	cident Report was					
		2/12. The report					
		resident complained					
		s mean and nasty to					
		not help her move her					
		nt occurred on 8/12/12					
	•	he report also indicated					
	•	ed to the Unit Manager					
	•	nt had no injury. The					
		ned as completed by					
	the RN Unit Ma	anager.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155764	B. WING		10/09/2012
NAME OF I	PROVIDER OR SUPPLIEI		STREET .	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	-KOVIDER OR SUFFEIEI	X.	101 W	87TH AVE	
SPRING	MILL HEALTH CAI	MPUS	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	The facility's in	vestigation was			
	reviewed. The	e investigation indicated			
	CNA #1 was id	dentified as the CNA			
	working on the	night shift 8/11/12			
	through 8/12/1	2. The employee time			
	card record for	CNA #1 indicated the			
	employee did	work the night shift			
	starting on 8/1	2/12 at 9:57 p.m. and			
	ending on 8/13	3/12 at 6:13 a.m.			
	When interview	wed on 10/4/12 at			
	11:50 a.m., LP	N #6 indicated she was			
	in the resident	's room with a CNA on			
	8/12/12 and th	e resident voiced the			
	concern that a	CNA on the night shift			
		n to her. The LPN			
	indicated she f	filled out a concern form			
	at the time and	reported the concern			
		nager, who was in the			
		me the above concern			
	was reported to				
	When interview	wed on 10/4/12 at			
	12:25 p.m., the	e Unit Manager			
	-	/12/12 at around 3:00			
		reported to her that			
	•	ad indicated a staff			
		nean to her. The Unit			
		ated she was in the			
		me the Nurse reported			
	-	e Unit Manager			
		did not report this to			
		ne next day when she			
	informed the D	-			
		ated the DON then			
	I wanayer mulc				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURV COMPLETED 10/09/2012	•		
	PROVIDER OR SUPPLIEF	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COI	(X5) MPLETION DATE		
	instructed her t #B.	to interview Resident						
	12:05 p.m., the indicated CNA at the time the reported to the the facility policy discovered indicated the Coshift on 8/12/12 reported on 8/2 The facility policy had 9/16/2011. The policy had 9/16/2011. The Executive Dire for investigatin allegations. The Incident and was to be refer procedures. The upon identification abuse and negligible and reprovided and monitoring, monit	Unit Manager as per cy. The Executive ted the CNA time card CNA worked the night 2 after the incident was 12/12 at 3:45 p.m. icy, titled "Abuse and dural Guidelines," was 0/4/12 at 12:45 p.m. a revised date of e policy indicated the ctor was accountable g and reporting he policy also indicated ad Accident Program red to for investigation he policy also indicated tion of suspected elect protection for the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			A. BUILI	DING	NSTRUCTION 00	(X3) DATE (COMPL 10/09/	ETED
		100704	B. WING	_		10/09/	ZU 1Z
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	//PUS			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		*		TAG	BEHREIMET		DATE
		diagnoses included,					
	but were not limited to, coronary artery disease, atrial fibrillation (an						
	_	beat) and congestive					
	_	he 9/21/12 Minimum					
	Data Set (MDS						
	,	dicated the resident's					
	BIMS (Brief Int	erview for Mental					
	,	vas 15. This indicated					
	the resident's o	ognitive patterns were					
	intact.						
		ncern form was					
	_	cial Service #2 on					
		p.m. The form					
		esident informed the					
		mber he would like to					
	•	nit Manager or DHS					
	(Director of He	•					
	"	NA on the midnight					
	shift had refuse	•					
	can it himself.	ed and told him he do					
	Carric IIII ISCII.						
	An Indiana Sta	te Department of					
		Report Form was					
		0/4/12 at 10:30 a.m.					
		n indicated an incident					
	•	22/12 at 3:45 p.m. The					
	incident descrip	otion indicated the					
	resident verbalized to Social Service						
	#2 that a CNA on the midnight shift refused to help him reposition in bed.						
	The report indi	cted the Immediate					
	Action taken in	cluded suspension of					

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Event ID: FVND11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764			LDING	NSTRUCTION 00	(X3) DATE SI COMPLE 10/09/2	TED
		100704	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	10/03/2	.012
NAME OF I	PROVIDER OR SUPPLIE	R		1	37TH AVE		
SPRING	MILL HEALTH CA	MPUS			LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·	+	TAG			DATE
	the CNA and i investigation.	illiating an					
	investigation.						
	Review of the	facility's investigation					
		OON interviewed					
		nd CNA #6 on 9/25/12.					
		A #6's time card records					
		CNA worked the night					
		2. The CNA started					
		.m. on 9/23/12 and					
	1	n 9/24/12 at 6:03 a.m.					
	When interviev	wed on 10/4/12 at 1:10					
		cal Support Nurse					
	l •	Social Service staff did					
		nagement of the					
		he staff morning					
		24/12, and the Social					
	Service staff in	ndicated they then					
	informed her t	he resident's concern					
	was an allegat	ion of abuse and					
	needed to be i	nvestigated and an					
	investigation v	vas started.					
	When interview	wed on 10/4/12 at 1;15					
	l •	cutive Director indicated					
	she was first a	ware of the resident's					
	concern at the	9/24/12 morning staff					
	_	nstructed the DON to					
		stigation. The					
		ector indicated the CNA					
	•	nded at the time of the					
	_	e Executive Director					
		CNA did not work after					
	9/24/12 when	the allegation was first					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155764	B. WIN	G		10/09/	2012
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>		101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	/IPUS		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	brought up by	Social Service at the					
	9/24/12 morning staff meeting.						
	Neglect Proced reviewed on 10 The policy had 9/16/2011. The Executive Director investigating allegations. The Incident and was to be refer procedures.	ne policy also indicated d Accident Program red to for investigation					
	identification of neglect protect resident is to be included 1:1 me the resident, ar	nding the outcome of					
	Neglect Proced reviewed on 10 The policy had 9/16/2011. The Accident and Ir be completed Accident Prograto for investigation policy indicated	cy, titled "Abuse and dural Guidelines," was 0/4/12 at 12:45 p.m. a revised date of e policy indicated an incident Report was to and the Incident and am was to be referred tion procedures. The diff the Executive Director ied of allegations of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/09/	2012
NAME OF P	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ately. The policy					
	indicated the Executive Director was accountable for investigating and						
		· · · · · · · · · · · · · · · · · · ·					
		ations. The policy also itial report was to be					
		diately and reported to					
		state agencies within					
	not more the 2	•					
	A.4. The recor	rd for Resident #E was					
		0/4/12 at 10:30 a.m.					
		diagnoses included,					
		nited to, dementia,					
		ase, coronary artery					
		igh blood pressure.					
	ŕ						
	The 7/12/12 M	inimum Data Set					
	(MDS) admissi	on assessment					
	indicated the re	esident's BIMS (Brief					
	Interview for M	ental Status) score					
	was 6. The sc	ore indicated the					
		nitive patterns were					
	severely impai	red.					
		rsing Admission					
		Data Collection					
		esident was admitted					
		the resident had no					
		resent but did have a					
	1	viors. The Mood and					
		of Care included on the					
	Data Collection above form indicated						
	· -	oproach the resident in					
		r, assess the resident					
	Tor benaviors,	provide medication per					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155764	B. WIN	G		10/09/2012
NAME OF P	PROVIDER OR SUPPLIEF	\			DDRESS, CITY, STATE, ZIP CODE	
CDDING		ADUC			B7TH AVE	
SPRING	MILL HEALTH CAN	WIPUS		MERKIL	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		, , , , , , , , , , , , , , , , , , ,	+	IAG		DATE
	resident to Soc	lers, and refer the				
	resident to 300	cial Services.				
	An "Altercation	/Concern				
		Assessment and				
		orm was initiated by				
		n 7/10/12 at 5:00 p.m.				
	_	ated the resident threw				
		er at another resident in				
	_	n. The form indicated				
	_	id cognitive or memory				
		d difficulty following				
	•	understanding. The				
		date section on the				
		pleted by the Nurse				
	-	ne form. Updates				
		d to remove the				
		he situation, engage				
	the resident in	0 0				
		nily visits. The form				
	was reviewed l	•				
		ry Team) on 7/11/12.				
		the form was signed				
	by four staff me	embers which included				
	ADON, Nursing	g staff and Social				
	Worker #1. Th	ere were no other				
	interventions a	dded by the IDT team.				
	The name of th	ne resident who				
	Resident #E th	rew the glass of water				
	at was not liste	ed on the above form.				
	Review of the	Social Service				
		s indicated there were				
	_	ice progress notes				
	related to the a	. •				
	. 5.4.04 10 1.10 0					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE S COMPL		
ANDILLAN	OI CORRECTION	155764		LDING	00	10/09/	
		100707	B. WIN			10/09/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			37TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	When interview 11:00 a.m., the Nurse indicated cup of water at at a staff member Clinical Support there was no In Report availably resident to read to notify the incident. To Nurse indicated records available above incident Indiana State Eas required. When interview p.m., CNA #7 in present on 7/10 threw a cup of The CNA indicated she as she was OK and threw a cup at	ved on 10/9/12 at Clinical Support de the resident threw a Resident #J and also per on 7/10/12. The the Nurse also indicated incident/Accident de related to the above dent altercation. The the Nurse indicated the requires staff to cident Report related esident altercations de Executive Director of the Clinical Support de there were notole to indicate the was reported to the Department of Health and on 10/9/12 at 1:10 andicated she was 10/12 when Resident #E water at Resident #J. ated both the residents the table along with usband. The CNA asked Resident #E and then Resident #E and then Resident #E		TAG	DEFICIENCY)		DATE
		Interim DON (Director					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/09	LETED
	PROVIDER OR SUPPLIER		101 W 8	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
IAG	of Nursing) ind Assistant Directime of the about The Interim DC resident to resident to resident to resident to resident to resident to resident at the following dapresent at this Director of Nurset that time was incident. The facility polity Neglect Procedure and Interior and	icated she was the stor of Nursing at the eve 7/10/12 incident. ON indicated the dent altercation was a IDT morning meeting ay and the DON was meeting. The Interim sing indicated the DON is to "follow up" with the every titled "Abuse and dural Guidelines," was 0/4/12 at 12:45 p.m. a revised date of the policy indicated an incident Report was to and the Incident and it is am was to be referred the Executive Director ited of allegations of ately. The policy executive Director was in investigating and ations. The policy also itial report was to be diately and reported to state agencies within	IAG	DEPALENCT)		DATE
	Incident Repor	cy, titled "Accident and ting Guidelines," was 0/4/12 at 2:00 p.m. The				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	COME	E SURVEY PLETED
		155764	B. WIN	G		10/09	9/2012
	PROVIDER OR SUPPLIER			101 W 8	ADDRESS, CITY, STATE, ZIP CO 37TH AVE LLVILLE, IN 46410	DDE	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
	policy was date	ed 11/2010. The policy					
		ccident and Incident					
		e completed for known					
		abuse allegations. The					
		the forms were to					
	include the circ						
		e occurrence, names of					
	_	eir accounts of the					
		the statements were					
		by the Administrative					
	staff. The police	•					
	•	dents, and allegations					
	of abuse, inclu	_					
	•	e, were to be reported					
		•					
	•	ent supervisor as soon or when information of					
		earned. The policy					
		reporting of incidents,					
		abuse to state and					
	federal agencie						
		h agency guidelines.					
		indicated the Accident					
	and Incident fo	IIII					
	 A.E. The	d for resident # 1					
		d for resident #J was					
		0/9/12 at 12:00 p.m.					
		diagnoses included,					
		nited to, anxiety,					
	depression, an	d high blood pressure.					
	The 7/47/40 M	nimum Data Cat					
		nimum Data Set					
	, ,	on assessment					
		esident's BIMS (Brief					
		ental Status) score					
	was 5. This ind	dicated the resident's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 10/09/	ETED	
	PROVIDER OR SUPPLIER		p. wirk	STREET A	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	cognitive skills impaired.	for were severely					
	Nursing Asses Collection note There was no or resident being resident to resi 7/10/12. There "Altercation/Co Assessment ar initiated by Nur There was no or assessment of	ncern Circumstance nd Intervention" form rsing staff on 7/10/12. documentation of an the resident's physical al status related to the					
	11:00 a.m., the Nurse indicated threw a cup of and also at state The Clinical Sushe identified Fresident who Rocup of water or 7/10/12 resident Altercation repusals on Incider available related resident to resident to resident.	ort. The Clinical also indicated there tt/Accident Report					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	155764	A. BUI	LDING	00	10/09/	
		133704	B. WIN	_		10/03/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	MILL HEALTH CAN	MPUS			37TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility protocol	requires staff to					
	complete an In	cident Report related					
	to resident to re	esident altercations					
	and to notify th	e Executive Director of					
	the incident. T	he Clinical Support					
	Nurse indicated	d the above occurrence					
	should have be	een documented on an					
	"Altercation/Co	ncern Circumstance					
	Assessment ar	nd Intervention form in					
	the Resident #	J's clinical record					
	including follow	up assessment of the					
	_	lition as per the facility					
	policies.						
	•						
	B. The facility	Employee Files were					
	•	0/5/12 at 12:00 p.m.					
		#1 indicated the RN					
	was hired on 7	/26/12. There were no					
		ks in the employee's					
	file.	, ,					
	The facility poli	cy, titled "Abuse and					
		dural Guidelines," was					
	_	0/4/12 at 12:45 p.m.					
		a revised date of					
	9/16/2011.						
		cated all employees					
		eened for a history of					
		, or misappropriation of					
	_	the hiring process.					
		indicated screening					
		ing reference checks					
		current employers.					
	non previous/	arront omployers.					
	When interview	ved on 10/9/12 at					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155764	B. WING		10/09/2012
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated there checks in the last Executive Directly obtained the result of the last end of t	ector indicated they eference checks on Executive Director ence checks were to be employees during the according to the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л рин	DING	00	COMPLETED	
		155764	A. BUILDING B. WING			10/09/2012	
			b. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				B7TH AVE		
SDDING	MILL HEALTH CAN	ADI IS			LLVILLE, IN 46410		
	WILL HEALTH CAN	WI 03		MEIXIXII	LEVILLE, III 40410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG F0226	REGULATORY OR 483.13(c)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=K	ETC POLICIES The facility must of written policies are mistreatment, neous residents and mister property.	develop and implement and procedures that prohibit glect, and abuse of sappropriation of resident	F-0.0				11/00/2019
	A. Based on reinterview, the fatheir abuse and procedure was to the failure to ensure a thorous conducted for a bleeding noted cognitively impextensive assist completing action. The facility also thorough investing when an allegal indicating this rethat were not so vaginal tear was hospital record residents review abuse in the safety. Due to the investigation, the had the potential residents r	ugh investigation was a new onset of vaginal for a resident who was aired and required stance from staff for vities of daily living. In the fact of th	F02	26	F226 Resident #C was transferred to the hospital on 9/23/12 for evaluation and treatment of vaginal bleeding. We received verbal notificatio from the hospital that Resident #C was being admitted with postmenopausal vaginal bleeding. The ER reported da 9/23/12 also indicated no signs injury around the vagina. Our plan at that time was to communicate with the family to monitor this resident's condition with anticipated return to our facility. On October 5, 2012, ISDH surveyors initiated a sun at Spring Mill Health Campus investigate. Between the date 9/23/12 and 10/5/12, the facilith had no reason to investigate was believed to be a medical condition and diagnosis. As so as we were notified of suspicion that the injuries could have be self inflicted or otherwise inflict we immediately initiated a full investigation. This resident has already been transferred out of the facility when we learned of allegation and/or need for investigation. There was no additional need for corrective action(s) for this resident affectives.	ted s of on vey to s of y /hat on en ted, d f f the	11/08/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		155764	A. BUI B. WIN	LDING		10/09/2	2012
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			87TH AVE		
SDDING	MILL HEALTH CAI	MPHS			87 TH AVE LLVILLE, IN 46410		
			ı		LL VILLE, IIN 707 IU		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	port and initiate			by this deficient practice. Fac	ility	
		in a timely manner for 2			did a house wide audit of all incident and accidents to valid	late	
	of 2 residents	in the sample of 3 who			a through investigation was	ialt	
	voiced mistrea	tment by staff and			completed and report to India	_{na}	
		and the employees			State Department of Health. I		
		allegations (Residents			other findings were noted. Au		
		nd failed to initiate an			was completed on 10/5/2012.		
	· · ·	nd report a resident to			Department Heads were in		
		ation for 1 of 2 resident			serviced on 10/5/2012 concer	ning	
					the Abuse & Neglect and	_	
		ercations reviewed in			Accident and Incident reportin	9	
		ital sample of 3.			guidelines. This inservice included the expectation that a	.	
	(Residents #E	and #J)			reports of alleged abuse must		
					immediately reported to the		
	The Immediate	e Jeopardy began on			Executive Director and/or Director	ector	
		Resident #C was			of Health services . An		
		a new onset of vaginal			investigation should begin		
		an investigation into the			immediately with to include		
	1	not initiated. The facility			reporting of required state		
		_			agencies per our Abuse Policy		
		ctor, Interim Director of			and the Elder Justice Act. Sta	att	
		es, and Clinical Support			accused of abuse will be suspended pending		
		tified of the Immediate			investigation. In addition to		
		0/4/12 at 4:50 p.m.			department heads being traine	_{ed,}	
		e Jeopardy was			all staff have been inserviced		
	removed on 10	0/5/12 at 6:00 p.m., but			this policy. Facility staff		
		e remained at the lower			conducted a survey on 10/5/2		
	· ·	erity of pattern, no			of interviewable residents ens		
		th potential for more			they feel safe, their needs are		
		arm that is not			being met and privacy and dig	Inity	
	Immediate Jed				maintained. All concerns identified during this survey ha		
	i iiiiiieulale Jec	paruy.			been reported to facility staff		
	D D- 1				addressed as indicated. Any	u.iu	
		ecord review and			issues pertaining to known,		
	interview, the f	-			suspected or alleged/abuse ha	ave	
	implement the	ir abuse and neglect			been reported to the Indiana		
	policy and prod	cedure, related to the			State Department of Health w	/ith	
		re reference checks			investigations in process as		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155764	B. WIN			10/09/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410		
			_				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	+	TAG			DATE
	•	d during the hiring			applicable.		
	•	of 5 employee files			Resident interviews will be		
	reviewed (RN :	#1).			conducted with five (5) residents		
					weekly will be conducted by Social Services or designee to ensure		
	Findings includ	de:			residents feel safe, needs are met		
					and privacy/dignity is maintained.		
	A.1. The close	ed record for Resident			Resident to resident altercations wa	ıs	
		red on 10/4/12 at 1:30			also reviewed with staff to make		
		dent's diagnoses			sure everyone had a clear		
	•	vere not limited to,			understand that these should also		
	•	·			be considered as an allegation of		
		neimer's disease, major			abuse in some instances. Audits to		
	•	order, high blood			continue 5 residents weekly for 90		
	•	coronary artery			days; then 3 residents weekly for 60)	
		esident was sent to the			days; then 2 residents weekly for 30)	
	hospital on 9/2	3/12.			days. We will review in QA monthly	,	
					until substantial compliance is		
	Review of the	8/16/12 Minimum Data			achieved.		
	Set (MDS) adn	nission assessment			Resident concerns will be		
	indicated the re	esident's BIMS (Brief			reviewed by the Executive Director or designee five (5) til	mes	
		lental Status) score			per week with timely reporting		
		dicated the resident's			known, suspected or alleged	.	
		rns were severely			abuse and immediate initiation	n of	
		assessment also			the investigative process. This		
	-	esident required			will be an ongoing process.We	9	
		•			reviewed all personnel files to		
		stance from staff for			ensure we were in compliance with all aspects of our Abuse a		
		ne, eating, dressing,			Neglect Procedural Guidelines		
		The assessment also			Part of our guidelines include		
		esident required			obtaining reference checks for	all	
	extensive assis	stance of two or more			employees. Any personnel file		
	persons for be	ed mobility and			identified that were missing		
	transfers.				reference checks have been		
					corrected. Department Heads	i	
	A care plan, in	itiated on 8/13/12,			have been re-trained on the		
	-	esident had impaired			importance of obtaining these reference checks. Our HR		
		as evidenced by			Manager will oversee complian	nce	
	Cognitive skills	as evidenced by	1		I manager will oversee compilar		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL 10/09/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	10,00,	
SPRING	MILL HEALTH CAN	/IPUS		MERRIL	LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	memory probled plan, initiated of the resident had communication as her primary English. Care included for a communicating The 9/2012 Nureviewed. The 9/23/12 was continued to be utilized as communicating The 9/2012 Nureviewed. The 9/23/12 was continued to the 9/23/12 was continued to the evaluation and and orders were resident to the evaluation and no assessment vaginal area in only one entry entry was made was no documentation and the evaluation and the evaluation and was no documentation and the evaluation and the evaluation and the evaluation and was no documentation and the evaluation and th	In the potential for, language was not plan interventions communication board is an alternate form of language. When the series is a serie			with this expectation. All new employees hired will have reference checks completed before they complete orientat This will be reported to QA Committee monthly x 4 month then randomly thereafter unticoncern is determined resolve by QA committee. QA will monitor for any trends and marecommendation to plan of correction as needed. QA will monitor for six (6) months or compliance is achieved. Correction of citation 11/8/12.	ion. ns ed ake ill until	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/09/	2012
NAME OF P	ROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		re was a faxed date of					
		on the top right hand					
		ng they were faxed to					
	•	/28/12. Emergency					
	Room records						
		esident was sent to the					
		om for an evaluation of					
	_	g, and the resident					
	had a history o	•					
		and cardiac surgery.					
		dicated there was					
	_	d the vagina, no signs					
		d the vagina, and blood					
		arge from the vagina.					
	The records als	so indicated the					
	Physician was	unable to evaluate the					
	cervix due to th	ne resident being					
	uncooperative,	as the resident did not					
	follow comman	ds and was not					
	orientated.						
	·	pital records were					
		/4/12 at 3:00 p.m. A					
		Il Medicine note,					
		he Physician who was					
		ittending Physician at					
	,	was admitted from,					
		esident was not able to					
		anything, had severe					
	Alzheimer's dis	ease, and the resident					
	was seen in the	e Emergency Room.					
	The note confir	med the resident was					
	having bleeding	g from the vagina and					
	not the rectum.	A pelvic examination					
	indicated the re	esident was actively					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/09/	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE B7TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	bleeding was nexam. The not resident was sthysterectomy a bleeding was nexus obtained for furnote also indicating the hard object and rupture [sic] uriting the same ulcer, powith a hard object and intended the Grand	and the cause of the out very clear and a nsultation was to be other evaluation. The ated the resident vaginal wall cancer of ssibility of maceration ect should also be demented patient which sed laceration and Consult Note dated ed the resident was ginal bleeding and an other anesthesia was 25/12 Physician completed by the oding Physician, synecologist "observed a tear and other than is a yellow fluid came concerned that she may be ready and wall with a dimay have even nary bladder wall."				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155764	B. WIN			10/09/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		is were noted at the					
	. •	nd some bleeding was					
	noted. The ab	rasions were					
	cauterized.						
	A 9/26/12 Phys	sician Progress Note,					
	completed by t	he resident's attending					
	Physician, indi	cated the resident had					
	a pelvic exami	nation under general					
	anesthesia and	d was found to have a					
	tear in the vagi	ina. The Assessment					
	_	note indicated "vaginal					
		she masturbate with a					
	_	was it a sexual abuse					
	I	home cannot be					
		patient is demented					
	and cannot giv	•					
	and cannot giv	o a motory					
	When interviev	ved on 10/4/12 at 2:10					
	p.m. Social Wo	orker #1 indicated the					
	resident's son	came into the facility to					
	pick up the res	ident's dentures and					
	eye glasses or	n 9/24/12. The Social					
	Worker indicate	ed she gave them to					
	the resident's	son at that time. The					
	Social Worker	indicated the resident's					
		anything about the					
		dition at this time. The					
		ndicated the resident's					
		to the facility another					
		above date. The Social					
		ed he came back to the					
		other person. The					
	I	indicated she could not					
	remember the	exact date of this visit.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL			
		155764	B. WIN	G		10/09/	2012		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	_			
			101 W 87TH AVE						
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
		rker indicated she							
		how he was doing and							
		r told the son "don't							
	, , , ,	The Social Worker							
		hen asked the son and							
	the other visito	r if there was							
		ng and requested they							
	come into her	office to talk. The							
	Social Worker	indicated the other							
	visitor indicated	d "she has injuries and							
	they are not se	If inflicted, and we may							
	have a case."	The Social Worker							
	indicated to bo	th of them she was							
	going to call the	e Executive Director to							
	come and talk	with them. The Social							
	Worker indicate	ed she tried calling and							
		cutive Director while							
	' ' '	still in her office but							
		answer, and the							
		and the other visitor							
	gave her a bus	iness card and left the							
	_	cial Worker indicated							
		to the Executive							
	Director's office	e and informed her							
		ened in her office, and							
		indicated the resident							
		at were not self inflicted							
	,	ard to the Executive							
	Director.								
	When interview	ved on 10/4/12 at 2:35							
		utive Director indicated							
	' '	ker informed her of the							
		and the visitor being in							
		indicating the resident							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN			10/09/	ZU 1Z
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDDING	NAUL LIEALTILOAA	ADL IC			B7TH AVE		
SPRING	MILL HEALTH CAN	/IPU5		MEKKIL	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nal bleeding and it was					
		ed." She indicated this					
		Thursday or Friday.					
		Director indicated at					
		reviewed the resident's					
		and called the hospital					
	_	ncy Room records.					
		Director reviewed the					
		cords that were in the					
		rd and indicated the					
		written on the records					
		ne visitors were in and					
this date was 9/28/12. The Executive							
		ed she also then					
	· •	Nurse who was caring					
	for the resident	at the time she was					
	sent to the hos	pital on 9/23/12, the					
	CNA who was	working that shift, and					
	the Nurse who	worked the shift					
	before. The Nu	urse who sent the					
	Resident #C to	the hospital for the					
	vaginal bleedin	g indicated this was					
	the first time th	e resident had any					
	vaginal bleedin	g. The Nurse on the					
	night shift indic	ated there were no					
	problems with t	the resident in the night					
	shift.	ŭ					
	When interview	ved on 10/4/12 at 3:20					
	p.m., the Execu	utive Director indicated					
	·	ne male CNA caring for					
	-	the day she was sent					
		rgency Room and					
		had noticed any					
		resident's brief or if					
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	IG		10/09/	2012
NAME OF I	DOWNDED OD SLIDDLIEL		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF			101 W 8	37TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		n any problems with the					
	resident, and none were voiced. The						
		ctor indicated the three					
	staff members were interviewed, but no written statements were available. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was						
	_	0/4/12 at 12:45 p.m.					
		a revised date of					
		e policy indicated the					
	Executive Director was accountable						
		g and reporting					
	_	ne policy also indicated					
	_	d Accident Program					
		rred to for investigation					
	procedures.	Ted to for investigation					
	procedures.						
	The facility pol	icy, titled "Accident and					
	Incident Repor	ting Guidelines," was					
	reviewed on 10	0/4/12 at 2:00 p.m. The					
	policy was date	ed 11/2010. The policy					
	indicated all ac	ccidents, incidents, and					
	allegations of a	abuse, including injuries					
	of unknown so	urce, were to be					
	reported to the	department supervisor					
	•	covered or when					
	information of	occurrence is learned.					
		indicated reporting of					
		dents, and abuse to					
	•	ral agencies shall be in					
		th agency guidelines.					
		J J					
	The Immediate	e Jeopardy that began					
	on 9/23/12 was	s removed on 10/5/12					

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	OF CORRECTION OF CORRECTION 155764 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/09/2012			
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION			
	when the facility inserviced staff on the Abuse Policy and procedures and reporting any unusual occurrence to their supervisor at the time of the occurrence. All staff working on 10/5/12 had been inserviced. The facility interim Director of Nursing provided a listing of all facility employees with a monitoring system to ensure each employee was inserviced prior to the start of their next scheduled shift. Department Heads were inserviced on the facility Accident and Incident Reporting guidelines to include immediate reporting to the Executive Director/DHS (Director of Health Services) and initiation of investigations. Random verbal audits of several residents were initiated to ensure residents felt safe and their needs were addressed. The audits were to continue. An investigation of Nursing Staff assigned as working the unit for 24 hours prior to the incident was initiated. Incident logs from 7/2012 to current were reviewed for any other potential occurrences. The Immediate Jeopardy was removed on 10/5/12 at 6:00 p.m., but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	IG		10/09/2012	
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
				1	B7TH AVE		
SPRING MILL HEALTH CAMPUS			MERRIL	LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG				TAG	Dia relative 17		DATE
		eded to be provided to returning to work and					
		ded to ensure ongoing					
	1	s in place to ensure all					
		•					
	allegations of abuse or mistreatment were evaluated thoroughly.						
	Word Ovaldated	a diolouginy.					
	A.2. The recor	d for Resident #B was					
		0/4/12 at 10:00 a.m.					
		diagnoses included,					
	but were not lir	•					
		st cancer, and coronary					
		The 7/5/2012					
		Set (MDS) admission					
		dicated the BIMS (Brief					
	Interview for M	ental Status) score					
	was 15. This s	score indicated the					
	resident's cogr	nitive patterns were					
	intact.						
ı		te Department of					
		t Report Form was					
		0/4/12 at 10:30 a.m.					
		eport form indicated an					
		ed on 8/12/12 at 3:45					
	l •	indicated the resident					
	l .	id not want the CNA					
	l '	ght shift taking care of					
		A was mean and nasty.					
	•	cated the Immediate					
		cluded suspension of					
		itiating an investigation.					
		indicated the Executive					
	Director was no	otified.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMP	ESURVEY LETED 0/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	initiated on 8/1 indicated the that a CNA was her and would leg. The incide at 3:45 p.m. This was report and the reside report was significated. The CNA #1 was in working on the through 8/12/1 card record for employee did starting on 8/1 ending on 8/13. When interview 11:50 a.m., LP in the resident 8/12/12 and the concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and to the Unit Markey would be a concern that a had been mean indicated she fat the time and the Unit Markey would be a concern that a had been mean indicated she fat the time and the unit Markey would be a concern that a concern tha	e investigation was e investigation indicated dentified as the CNA e night shift 8/11/12 2. The employee time of CNA #1 indicated the work the night shift 2/12 at 9:57 p.m. and 8/12 at 6:13 a.m. Inved on 10/4/12 at the N #6 indicated she was so room with a CNA on the resident voiced the CNA on the night shift in to her. The LPN filled out a concern form the reported the concern mager, who was in the me the above concern					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/09/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	12:25 p.m., the indicated on 8/p.m. the Nurse Resident #B has member was manager indicated indicated she canyone until the informed the Danager indicated her table. When interview 12:05 p.m., the indicated CNA at the time the reported to the the facility policible. Director indicated indicated the Cashift on 8/12/12 reported on 8/10 The facility policy had 9/16/2011. The policy had 9/16/2011. The Executive Director investigating for investigating the residual process.	12/12 at around 3:00 reported to her that ad indicated a staff nean to her. The Unit ated she was in the me the Nurse reported e Unit Manager lid not report this to e next day when she ON. The Unit ated the DON then to interview Resident If was not suspended allegation was Unit Manager as per ey. The Executive ated the CNA time card allegation was Unit Manager as per ey. The Executive ated the CNA time card allegation was Unit Manager as per ey. The Executive ated the CNA time card allegation was Unit Manager as per ey. The Executive ated the CNA time card allegation was after the incident was allegated the						

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Event ID: FVND11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				ETED
		155764	B. WIN			10/09/2012	
NAME OF B	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d Accident Program					
		red to for investigation					
	I -	ne policy also indicated					
	•	tion of suspected					
	abuse and neg	lect protection for the					
	safety of the re	esident is to be					
	provided and n	nay included 1:1					
	monitoring, mo	ving of the resident,					
	and suspendin	g employees pending					
	the outcome of	f the investigation.					
		G					
	A.3. The recor	d for Resident #D was					
	reviewed on 10	0/4/12 at 11:30 a.m.					
		diagnoses included,					
		nited to, coronary					
		atrial fibrillation (an					
		beat) and congestive					
	•	he 9/21/12 Minimum					
	Data Set (MDS	,					
		dicated the resident's					
	•	erview for Mental					
	l '	vas 15. This indicated					
	the resident's of	cognitive patterns were					
	intact.						
	<u> </u>	_					
		ncern form was					
	1	cial Service #2 on					
		p.m. The form					
	indicated the re	esident informed the					
	above staff me	mber he would like to					
	speak to the U	nit Manager or DHS					
	Director of He	•					
	1 '	NA on the midnight					
	shift had refuse						
		ed and told him he do					
		sa ana tola mili ne ao					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764 A. BUILDING DO COMPLE 10/09/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE	
155764 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE	/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE	
NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE	
SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
can it himself.	
An Indiana State Department of Health Incident Report Form was reviewed on 10/4/12 at 10:30 a.m. The report form indicated an incident occurred on 9/22/12 at 3:45 p.m. The incident description indicated the resident verbalized to Social Service #2 that a CNA on the midnight shift refused to help him reposition in bed. The report indicted the Immediate Action taken included suspension of the CNA and initiating an investigation. Review of the facility's investigation indicated the DON interviewed Resident #D and CNA #6 on 9/25/12. Review of CNA #6's time card records indicated the CNA worked the night shift on 9/23/12. The CNA started work at 9:57 p.m. on 9/23/12 and punched out on 9/24/12 at 6:03 a.m. When interviewed on 10/4/12 at 1:10 p.m., the Clinical Support Nurse indicated the Social Service staff did not inform management of the concern until the staff morning meeting on 9/24/12, and the Social Service staff indicated they then informed her the resident's concern was an allegation of abuse and needed to be investigated and an	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155764	B. WIN	G		10/09/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ODDINO	NAUL LIE AL TIL OAN	ADUO			B7TH AVE		
SPRING	SPRING MILL HEALTH CAMPUS			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	investigation w	as started.					
	Mhon intoniou	ved on 10/4/12 at 1;15					
		·					
		utive Director indicated ware of the resident's					
		9/24/12 morning staff					
		istructed the DON to					
	initiate an inve						
		ctor indicated the CNA					
		nded at the time of the					
	•	e Executive Director					
	_	CNA did not work after					
		the allegation was first					
		Social Service at the					
		ng staff meeting.					
	0,2 1, 12 111011111	ig clair mocarig.					
	The facility pol	icy, titled "Abuse and					
		dural Guidelines," was					
	_	0/4/12 at 12:45 p.m.					
		a revised date of					
		e policy indicated the					
	Executive Dire	ctor was accountable					
	for investigatin	g and reporting					
	_	ne policy also indicated					
		nd Accident Program					
		rred to for investigation					
	procedures.	J					
	· -						
	The policy also	indicated upon					
		f suspected abuse and					
		tion for the safety of the					
	•	e provided and may					
		onitoring, moving of					
	the resident, a						
		nding the outcome of					

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	OF CORRECTION OF CORRECTION 155764 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 09/2012	
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	the investigation. The facility policy, titled "Abuse and Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated an Accident and Incident Report was to be completed and the Incident and Accident Program was to be referred to for investigation procedures. The policy indicated the Executive Director was to be notified of allegations of abuse immediately. The policy indicated the Executive Director was accountable for investigating and reporting allegations. The policy also indicated an initial report was to be initiated immediately and reported to the applicable state agencies within not more the 24 hours A.4. The record for Resident #E was reviewed on 10/4/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer disease, coronary artery disease, and high blood pressure. The 7/12/12 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 6. The score indicated the resident's cognitive patterns were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155764	B. WIN	G		10/09/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDEN ON SOITEEL	•			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	IMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	severely impaired.						
		rsing Admission					
	Assessment &	Data Collection					
	indicated the re	esident was admitted					
	on 7/5/12 and	the resident had no					
	behaviors at pr	resent but did have a					
	history of beha	viors. The Mood and					
	Behavior Plan	of Care included on the					
	Data Collection	n above form indicated					
	staff were to ap	oproach the resident in					
a calm manner, assess the resident							
	for behaviors, i	provide medication per					
	-	lers, and refer the					
	resident to Soc						
	An "Altercation	/Concern					
	Circumstance A	Assessment and					
	Intervention" f	orm was initiated by					
		n 7/10/12 at 5:00 p.m.					
	_	ated the resident threw					
		er at another resident in					
	_	n. The form indicated					
		id cognitive or memory					
		d difficulty following					
	•	understanding. The					
		date section on the					
	•	pleted by the Nurse					
	-	•					
		ne form. Updates d to remove the					
		he situation, engage					
	the resident in	•					
	_	nily visits. The form					
	was reviewed l	•					
	(Interdisciplina	ry Team) on 7/11/12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155764		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/09/2012		
	PROVIDER OR SUPPLIER		J. WII.	STREET A	ADDRESS, CITY, STATE, ZIP CODE 37TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
TAG	This section of by four staff me ADON, Nursing Worker #1. The interventions at The name of the Resident #E that was not listed. Review of the Section Progress Notes no Social Service related to the at When interview 11:00 a.m., the Nurse indicated cup of water at at a staff member Clinical Support there was no In Report available resident to resident to resident to resident to resident to resident to resident. The Nurse indicated records available above incident.	the form was signed embers which included g staff and Social ere were no other dded by the IDT team. He resident who rew the glass of water d on the above form. Social Service indicated there were ice progress notes		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ie i	DATE
	as required.						

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				ETED
		155764	B. WIN			10/09/2012	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			37TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	When interviev	ved on 10/9/12 at 1:10					
		indicated she was					
		0/12 when Resident #E					
		water at Resident #J.					
	•	ated both the residents					
		t the table along with					
		usband. The CNA					
		asked Resident #J if					
		nd then Resident #E					
	threw a cup at						
	linew a cup at	Tier also.					
	When interview	ved on 10/9/12 at					
		e Interim DON (Director					
		icated she was the					
	· · · · · · · · · · · · · · · · · · ·	ctor of Nursing at the					
		ove 7/10/12 incident.					
		ON indicated the					
		ident altercation was					
		e IDT morning meeting					
	_	ay and the DON was					
	•	meeting. The Interim					
		rsing indicated the DON					
		s to "follow up" with the					
	incident.						
	The facility nell	iov titlad "Abusa and					
		icy, titled "Abuse and					
		dural Guidelines," was					
		0/4/12 at 12:45 p.m.					
		a revised date of					
		e policy indicated an					
		ncident Report was to					
	•	and the Incident and					
	_	ram was to be referred					
	to for investiga	tion procedures. The					
	policy indicated	d the Executive Director					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/09	ETED
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	abuse immedia indicated the E accountable for reporting allegation indicated an initiated immediate applicable and more the 24. The facility politicident Report reviewed on 10 policy was date indicated an Action Form was to be accidents and a policy indicated include the circulated include the circulated and the occurrence and to be reviewed staff. The policy accidents, included the department of abuse, included the department of abuse, included the department of the departme	cy, titled "Accident and ting Guidelines," was 0/4/12 at 2:00 p.m. The ed 11/2010. The policy ecident and Incident e completed for known abuse allegations. The dithe forms were to sumstances e occurrence, names of eir accounts of the dithe statements were by the Administrative by indicated all dents, and allegations ding injuries of ee, were to be reported ent supervisor as soon or when information of earned. The policy reporting of incidents, abuse to state and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155764	B. WIN	G		10/09/2012	2
NAME OF B	ADOLUDED OD GUDDU ED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		101 W 8	37TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CON	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	and Incident fo	rm					
	A.5. The recor	d for resident #J was					
	reviewed on 10)/9/12 at 12:00 p.m.					
		diagnoses included,					
		nited to, anxiety,					
		d high blood pressure.					
	depression, an	a mgn blood pressure.					
	The 7/17/12 Mi	inimum Data Set					
		on assessment					
	, ,	esident's BIMS (Brief					
		ental Status) score					
		dicated the resident's					
	_	for were severely					
	impaired.						
	The 7/12 Nure	es' Notes and Skilled					
		sment and Data					
	_						
		s were reviewed.					
		documentation of the					
	_	involved in any					
		dent altercation on					
	7/10/12. There						
	"Altercation/Co	ncern Circumstance					
	Assessment ar	nd Intervention" form					
	initiated by Nur	rsing staff on 7/10/12.					
	•	documentation of an					
		the resident's physical					
		Il status related to the					
	7/10/12 resider						
	altercation.	it to resident					
	ailei calluii.						
	 When interview	ved on 10/9/12 at					
		Clinical Support					
		d the Resident #E					
	I Mui se il luicale	u uic ivesineiil #E					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 10/09/2012	
		155764	B. WIN			10/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
000000	NAUL LIEATTI C	ADULO			B7TH AVE		
SPRING	MILL HEALTH CAN	/IPU5		MERKIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	water at Resident #J					
		ff member on 7/10/12.					
		ipport Nurse indicated					
		Resident #J in as the					
		esident #E threw the					
	•	n in reviewing the					
	7/10/12 resider						
	•	ort. The Clinical					
		also indicated there					
		t/Accident Report					
	available relate						
		dent altercation. The					
		t Nurse indicated the					
		requires staff to					
	-	cident Report related					
		esident altercations					
	_	e Executive Director of					
		he Clinical Support					
		d the above occurrence					
		een documented on an					
	"Altercation/Co	ncern Circumstance					
		nd Intervention form in					
	the Resident #	J's clinical record					
	including follow	up assessment of the					
	resident's cond	lition as per the facility					
	policies.						
		Employee Files were					
	reviewed on 10	0/5/12 at 12:00 p.m.					
	The file for RN	#1 indicated the RN					
	was hired on 7/	/26/12. There were no					
	reference chec	ks in the employee's					
	file.	-					
	The facility poli	cy, titled "Abuse and					

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	of correction identification number: 155764	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPLETED 10/09/2012
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W 87	DDRESS, CITY, STATE, ZIP CODE 7TH AVE LVILLE, IN 46410	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	Neglect Procedural Guidelines," was reviewed on 10/4/12 at 12:45 p.m. The policy had a revised date of 9/16/2011. The policy indicated all employees were to be screened for a history of abuse, neglect, or misappropriation of property during the hiring process. The policy also indicated screening included obtaining reference checks from previous/current employers. When interviewed on 10/9/12 at 10:00 a.m., the Executive Director indicated there were no reference checks in the RN's file. The Executive Director indicated they obtained the reference checks on 10/8/12. The Executive Director indicated reference checks were to be completed for employees during the hiring process according to the facility's Abuse Policy. This federal tag relates to Complaint IN00117473. 3.1-28(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155764	B. WING	·	10/09/2012
			_	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	R.		1 W 87TH AVE	
SPRING	MILL HEALTH CAN	MPUS		ERRILLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPRO	OPRIATE COM EL TION
TAG		LSC IDENTIFYING INFORMATION)	TAC	G DEFICIENCY)	DATE
F0250 SS=D	483.15(g)(1) PROVISION OF SOCIAL SERVIC	MEDICALLY RELATED			
	-	provide medically-related			
		attain or maintain the			
		le physical, mental, and			
	• •	l-being of each resident.	F0250		11/09/2012
	Based on reco		F0250	Correction action for those residents found to have be	
		acility failed to provide		affected by deficient practi	
		to a resident after a		included a review of Resid	
		dent alteration for 1 of		and #J at the time of this s	
	2 residents who	o were reviewed for		Residents were found to I	pe in no
	resident to resi	dent altercations in the		need of additional actions	
	sample of 3.			time. As part of this overa	
	(Resident #J)			process with a review of o	
	,			Abuse and Neglect Proced	
	Findings includ	le:		Guidelines, all residents in facility had the potential to	
	· ····································			affected by the same defic	
	The record for	Resident #J was		practice. Facility staff con	
		0/9/12 at 12:00 p.m.		a survey on 10/5/2012 of	
		diagnoses included,		interviewable residents en	
		nited to, anxiety and		they feel safe, their needs	
		-		being met and privacy and maintained. All concerns	dignity
	•	ne 7/17/12 Minimum		identified during this surve	v have
	Data Set (MDS	•		been reported to facility s	-
		dicated the resident's		addressed as indicated. A	
	•	erview for Mental		issues pertaining to knowr	
	•	vas 5. This indicated		suspected or alleged/abus	
		cognitive patterns were		been reported to the India	
	severely impair	red.		State Department of Heal investigations in process a	
				applicable.	
	Review of the	7/2012 Nurses' Notes		Resident interviews will be	
	and Nursing SI	killed Nursing		conducted with five (5) residen	ts
	Assessment ar	nd Data Collection		weekly will be conducted by So	cial
	forms indicated	d there was no		Services or designee to ensure	
		to the resident being		residents feel safe, needs are n	net
		resident to resident		and privacy/dignity is maintain	ed.
	involved in ally	resident to resident		Resident to resident altercation	ns was

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Facility ID: 010739

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155764	B. WIN			10/09/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
CDDING	NAUL LIEALTILOAN	ADUC			B7TH AVE	
SPRING	MILL HEALTH CAN	MPUS		MERKI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	altercation in 7	/10/12. Review of the			also reviewed with staff to make	
	7/2012 Social 9	Service Notes indicated			sure everyone had a clear	
		ocumentation of the			understand that these should also	
					be considered as an allegation of	
	_	involved in any			abuse in some instances. Audits to	
	resident to resi	dent altercation.			continue 5 residents weekly for 90	
					days; then 3 residents weekly for 60	
	When interview	ved on 10/9/12 at			days; then 2 residents weekly for 30	
		Clinical Support			days. We will review in QA monthly	
		d another resident			until substantial compliance is	
					achieved.	
	_	of water at Resident #J			Resident concerns will be	
		e Nurse identified the			reviewed by the Executive	
	resident as Re	sident #E.			Director or designee five (5) tir	nes
					per week with timely reporting	•
	When interview	ved on 10/9/12 at 1:15			known, suspected or alleged	
		ndicated she was			abuse and immediate initiation	of
	·	0/12 when Resident #E			the investigative process. This	5
	· •				will be an ongoing process.QA	
	•	water at Resident #J.			will monitor for any trends and	•
	The CNA indic	ated both the residents			make recommendation to plan	
	were seated at	the table along with			correction as needed. QA wil	
	Resident J's hu	sband. The CNA			monitor for six (6) months or u	ntil
	indicated she a	isked Resident #J if			compliance is	
					achieved. Correction of citation	n is
		nd then Resident #E			11/8/12	
	threw a cup at	ner also.				
	An "Altercation	/Concern				
	Circumstance A	Assessment and				
	Intervention" for	orm for Resident #E				
		/ Nursing staff on				
	· ·	•				
		p.m. The form				
		esident threw a glass of				
	water at anothe	er resident in the dining				
	room.					
	When interview	ved on 10/9/12 at				
	i i i i uu aliii., the	Clinical Support				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED		
		155764	B. WIN			10/09/	2012	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIEF	R	101 W 87TH AVE					
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		d the resident threw a						
	cup of water at	: Resident #J and also						
	at a staff meml	ber on 7/10/12.						
	When interviev	ved on 10/9/12 at 1:10						
	n m Social W	orker #1 indicated if						
	•	resident altercation						
		al Service was to						
	· ·							
		resident's psycho social						
	_	nental anguish in the						
		Notes. The Social						
	Worker also in	dicated the plan of care						
	for the resident	ts should be reviewed						
	related to any i	resident to resident						
	,	he Social Worker						
		vas not completed for						
	the resident.	vas not completed for						
	u ie resident.							
	0.4.04(.)(4)							
	3.1-34(a)(1)							
D0055								
R0000								
	This state is t	dential for discrete attends	l Doo	.00				
		dential finding is cited in	R00	000				
	accordance with	th 410 IAC 16.2-5.						
			- 1				ı	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155764	B. WIN			10/09/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				87TH AVE		
SPRING	MILL HEALTH CAN	1PUS			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0349	on each resident. maintained under employee of the fresponsibility. The follows: (1) Complete. (2) Accurately dod (3) Readily acces (4) Systematically Based on record interview, the factinical records complete related the correct cod resuscitation must the monthly Phystatements for residents review documentation (Residents #L at Findings included 1. The closed was reviewed of a.m. The residents revie	Noncompliance ust maintain clinical records These records must be the supervision of an acility designated with that e records must be as cumented. sible. organized. ord review and acility failed to ensure were accurate and ed to documentation of e status for easures was listed on ysician Order 2 of 8 sampled wed for code status in the sample of 8. and #M) e: record for Resident #L on 10/4/12 at 10:30 ent was admitted to ving from the Health 22/12. The resident's uded, but were not itis, right hip fracture,	R03	49	R349 All residents resident on assisted living will be reassess for code status with physician orders compared to resident and/or family wishes. This will completed by 11/8/12 for exist residents and will be done for new admissions. Measure purinto place in include retraining nurses and admissions staff of our procedures for obtaining a documenting code status. Correction action for future monitoring will include having nurses review code status as review physician orders every month. Any discrepancies will immediately investigated and corrected. Results of monthly rewrites and concerns with constatus will be reported to our controlly as needed for at least months and as needed or until achieve substantial compliance.	be ing all t of n nd they be de DA 6 l we	11/08/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155764	B. WIN		10/09/2012		
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		101 W 8	B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	orders indicate	d the resident's "Code					
	Status"						
		is "DNR" (Do Not					
		There were no written					
	·	ng the resident's code					
		•					
		n changed between					
	5/22/12 and 5/	31/12.					
	Review of the (6/2012, 7/2012,					
		2012 indicated the					
	· ·						
	resident's "Code Status" was checked						
	as "CPR" (Cardio Pulmonary						
	Resuscitation).						
	When interviev	ved on 10/4/12 at 2:00					
	p.m., LPN #5 ii	ndicated she was					
	•	iging the Assisted					
	•	he LPN indicated					
	_	as re admitted on					
		PN indicated the					
		e status was to be DNR					
		on the 6/12, 7/12,					
		should have been					
		nstead of CPR. LPN#5					
	indicated the P	Physician Order					
	Statements we	ere to be verified by					
	nursing staff ev	very month and					
	corrected.	-					
	2. The record	for Resident #M was					
		0/5/12 at 2:00 p.m. The					
		noses included, but					
		d to, high blood					
	-	eimer disease, vascular					
	dementia, and	diabetes mellitus. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155764	B. WING		10/09/2012
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
SDDING	MILL HEALTH CAN	ADI IS		87TH AVE LLVILLE, IN 46410	
				LLVILL, IIN 707 IU	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		dmitted on 6/10/12.	1110		5.112
	Toolachi was a	arrilled 517 57 157 12.			
	Review of the	7/12, 8/12, and 9/12			
		er Statements indicated			
		Code Status" was			
	blank. The Ph				
		cated either "DNR" or			
	"CPR" was to b				
	When interviev	ved on 10/9/12 at 9:50			
	a.m., LPN #5 iı	ndicated there were no			
	advanced dired	ctives or DNR form			
	completed and	the resident's code			
	status was to b	e CPR. The LPN			
		hould have been			
	checked on ea	ch monthly Physician			
	Order Stateme	nt.			
		dential finding relates to			
	Complaint IN00	0116313.			
			<u> </u>	1	

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